IN THE CIRCUIT COURT OF
OHIO COUNTY, WEST VIRGINIA

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In Re: Tobacco Litigation : Case No.
(Medical Monitoring Cases) : 00C-6000
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Deposition of PAUL D. THOMPSON taken pursuant to the West Virginia practice rules at the Sheraton Hotel, Bradley Field, Windsor Locks, Connecticut, before Elizabeth A. Zawacki, a Registered Merit Reporter and Notary Public in and for the State of Connecticut, on September 6, 2000 at 3:20 p.m.

A P P E A R A N C E S:

For the Plaintiffs:
NESS, MOTLEY, LOADHOLT, RICHARDSON & POOLE
28 Bridgeside Boulevard
Mt. Pleasant, South Carolina 29464
BY: RHETT D. KLOK, ESQ.

For the Defendant R.J. Reynolds Tobacco Company:
WOMBLE, CARLYLE, SANDRIDGE & RICE
150 Fayetteville Street Mall
Raleigh, North Carolina 27102
BY: SUSAN DAVIS CROOKS, ESQ.
JOHN W. O'TUEL, III, ESQ.

BOWLES, RICE, McDAVID, GRAFF & LOVE
600 Quarrier Street
Charlestown, West Virginia 25301
BY: COREY PELUMBO, ESQ.*

A p p e a r a n c e s :

For the Defendant Brown & Williamson:
DINSMORE & SHOHL
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Cincinnati, Ohio 45202
BY: MARY-JO MIDDELHOFF, ESQ.*

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500 Lee Street East
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BY: ROB J. ALIFF, ESQ.*

THE SEGAL LAW FIRM
810 Kanawha Boulevard East
Charleston, West Virginia 25301
BY: MICHAEL DAVENPORT, ESQ.* +
JOHN DASCOLI, ESQ.* +

For the Defendant Lorillard Tobacco Company:
THOMPSON, COBURN
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BY: RICHARD S. CORNFELD, ESQ.*

FARRELL, FARRELL & FARRELL
914 Fifth Avenue
Huntington, West Virginia 25779-6457
BY: RICHARD HOLTZAPFEL, ESQ.*

* Attended by telephone.
+ Present as noted in the transcript.

(In the presence of Mr. Davenport and the absence of Mr. Dascoli:)
(Thompson Deposition Exhibit 1 marked for identification.)
MR. KLOK: We'll only stipulate that the defendants have agreed that one objection would count as an objection for all of them. There's no objection to that.
P A U L A. T H O M P S O N ,
of [DELETED],
called as a witness, being first duly sworn by Elizabeth A. Zawacki, a Notary Public within and for the State of Connecticut, was examined and testified under oath as follows:
DIRECT EXAMINATION
BY MR. KLOK:
Q. Good afternoon, Dr. Thompson. How are you

doing?
A. Well, thank you.
Q. Would you please state and spell your name for the record.
A. Yes. My name is Paul Davis, D-A-V-I-S, Thompson, T-H-O-M-P-S-O-N.
Q. Could you please give your office address for the record.

A. My office is Preventive Cardiology, Hartford Hospital, 80 Seymour, S-E-Y-M-O-U-R, Street, Hartford, Connecticut 06102.
Q. Dr. Thompson, have you ever been deposed before?
A. Yes.
Q. When was the first time you were deposed?
A. I don't recall.
Q. Do you remember what it was about when you were first deposed?
A. It was about a medical malpractice case.
Q. Did you testify for the defendants or the plaintiffs in that case, if you remember?
A. I testified for the plaintiffs in that case.
Q. Do you know approximately how long ago that was?
A. I'm estimating. The best of my knowledge, it was around 1982 or maybe 1984. I hesitate to give that to you because I'm not exactly certain of the date, but you did ask for an estimate.
Q. So early '80s would be fair?
A. I think so.
Q. Have you ever been deposed on any other occasion?

A. I think that I have been deposed on other occasions. In fact, I know I've been deposed on other occasions, but I can't give you a list of them. There aren't very many. Probably three to five, something like that.
Q. Doctor, I'm going to ask you a series of questions, and unless you ask me to clarify the question, I will assume you understand it. Is that okay?
A. That's okay.
Q. This isn't a torture chamber. If you want to take a break, let me know. If you need to take a break for various reasons, let me know and we'll be happy to take a break and accommodate that.
A. Thank you.
Q. Dr. Thompson, have you ever testified in court before?
A. Yes.
Q. On how many occasions, if you know?
A. Approximately four.
Q. Do you remember each one of those four occasions?
A. I remember the following occasions: I testified once for a patient in a workman's compensation case; I testified for two malpractice

cases in the state of Rhode Island; and I testified for one malpractice case in Oklahoma City.
Q. Have you ever testified for defendants before in any of those cases?
A. No.
Q. So the four occasions you have testified have been for the plaintiff in their case?
A. Yes.
Q. I'm going to show you what's been marked as Exhibit Thompson 1 and see if this is a document you can recognize or identify.
MS. CROOKS: I can assure you that he will not recognize it and he cannot identify it.
Q. I recognize, just for the record, that these depositions have been done in a tizzy, and therefore it wouldn't surprise me that you haven't seen this document, but if we could, turn to notice Exhibit A which is towards the back of that document, and tell me if you see that.
A. I see Exhibit A.
Q. If you could turn to the next page where it's captioned, "Schedule of Documents." Do you see that, Dr. Thompson?
A. Yes.
Q. If you could, please read that page and

I'll ask you a few questions when you're finished.
A. "Schedule of documents. Plaintiffs request the following materials be brought to the deposition."
MS. CROOKS: You want him to read it out loud?
Q. You don't have to read it out loud, Doctor. Just read it to yourself, and I'll ask you a couple of questions about it.
A. Okay.
Q. Dr. Thompson, have you helped gather any of those documents for today's deposition?
A. Yes.
Q. I have a copy of your CV. I'll show you that shortly. I'll ask you questions regarding that, but setting the CV aside, are there any documents that you have brought today to this deposition that are documents that would be responsive to this request?
A. Yes.
Q. What documents are those?
A. I brought my file on the case, including all correspondence, notes, draft reports and other materials.
Q. Do you have copies of that file, or did

you just bring your file?
A. I brought the file.
MR. KLOK: I would request that the defendants provide us with a copy of his file after this deposition is concluded.
MS. CROOKS: I'll take that under advisement.
A. Much of it is just the case record, you

understand, from the two patients.
Q. Yes. Okay. What else is in there? You mentioned correspondence. What other materials are there, if we can go through them?
A. I brought what I have billed the law firm for the services that I have rendered to date. I brought the American College of Cardiology "Guidelines for Exercise Testing," which I was a member of and helped write, which forms some of my opinion. I did not bring any testimony, prior testimony, because I don't have that sort of stuff. I don't keep it.
Q. Okay.
A. I brought some notes that I made on the case, two yellow sheets of notes.
Q. You mentioned correspondence between you and the attorneys for the tobacco companies.

A. Right. I think I have one letter simply stating that we are going to meet or something. It's pretty sparse.
Q. If we could, why don't we go over what you have billed to date for this case, and if you could tell me, how much do you bill? What are your billing requirements for your time and testifying in cases?
A. My habitual charge is $400 an hour. I'm actually charging more in this case.
Q. Why is that?
A. Because I think this case has some potential threat to my reputation as a national expert in heart disease prevention, so I'm charging $450 an hour.
Q. You mentioned threat to your reputation. Why do you feel there's a potential threat to your reputation as a health --
A. Because I think physicians who are experts in this area of heart disease prevention, as I consider myself to be, are unwilling to participate to make the legal process equitable.
Q. Equitable in what sense?
A. With respect to tobacco companies.
Q. How much are you billing an hour for this

case?
A. $450.
Q. Is that the same whether you testify in deposition or trial?
A. Yes.
Q. And whether you review a file and don't testify?
A. Yes.
Q. Does that money go to you, or does it go to your hospital?
A. It goes to me personally.
Q. Do you have a separate corporation set aside for --
A. No.
Q. Besides -- and I think I got it right -- the American College of Cardiology, are there any other articles that you brought with you, medical

articles?
A. The people at the law firm sent me some articles, but I can guarantee you that they have not had the elastic removed because I didn't think I needed to read them.
Q. So as of today, have you had an opportunity to review the articles sent to you by the attorneys for the tobacco companies?

A. No. I mean, I know most of them pretty well, and I just kind of thumbed through.
Q. So some of those articles you may have already reviewed in your prior dealings; is that correct?
A. Right.
MR. KLOK: If we could, could we go off the record just quickly.
(Discussion off the record.)
Q. Are there any other articles besides the group articles that you received in the mail from the attorneys for the tobacco companies that you brought here today, and besides the one we have already mentioned, which is the American College of Cardiology guidelines?
A. I don't think so.
Q. If we could, why don't we look through the elastic band, and if you could just read the caption of each one of those articles, and what publication it came from; and if you recognize any of those in your own readings, please let us know. Let's start with the first one.
MS. CROOKS: Object; form.
Q. If you could look at the first one on top of that packet and read it, please.

A. "Angiographic Progression of Coronary Artery Disease in the Development of Myocardial Infarction."
Q. What publication is that?
A. That's from the "Journal of the American College of Cardiology."
Q. If we could just go through the next and read it, please.
A. "Family History of Heart Disease As an Independent Predictor of Death Due To Cardiovascular Disease."
Q. What journal is that?
A. "Circulation."
Q. The next one, please.
A. "Both Decreased and Increased Heart Rate Variability on the Standard 10-Second Electrocardiogram Predict Cardiac Mortality in the Elderly."
Q. What publication is that?
A. "American Journal of Epidemiology."
Q. Doctor, those three articles that you have just read, are those three that you are familiar with or you recognize as you sit here today?
MS. CROOKS: Object; form.
A. I recognize the Ambrose article.

Q. Which is, that's the second one you read?
A. The first one. I'm sorry. "Angiographic Progression."
Q. If you could read the fourth one, please.
A. "Coronary Risk Factors and Plaque Morphology in Men With Coronary Heart Disease Who Died Suddenly."
Q. What journal is that from?
A. "New England Journal of Medicine."
Q. Is that an article you're familiar with?
A. Yes.
Q. The next one, please.
A. The next one is entitled, "Screening Asymptomatic Adults for Cardiac Risk Factors."
Q. What journal or publication is that from?
A. Uncertain. It's a book.
Q. Is that something you're familiar with?
A. No.
Q. The next one, please.
A. "ACC/AHA Guidelines for Exercise Testing."
Q. What journal is that from or publication?
A. American College of Cardiology -- sorry. "Journal of the American College of Cardiology."
Q. Is that something you recognize?
A. Yes.

"ACC/AHA Guidelines for Exercise Testing: Executive Summary."
Q. Is that a publication you recognize?
A. Yes. I was an author on these last two.
Q. What journal is that from? I'm not sure we heard that.
A. "Circulation."
Q. The next one, if you will, Doctor.
A. "Maximal Exercise Test As a Predictor of Risk for Mortality From Coronary Heart Disease in Asymptomatic Men," from the "American Journal of Cardiology."
Q. Is that an article you recognize?
A. Yes.
Q. "Relation of the Site of Acute Myocardial Infarction To the Most Severe Coronary Arterial Stenosis At Prior Angiography."
Q. Okay, Doctor. What --
A. "American Journal of Cardiology."
Q. Is that also an article you recognize?
A. No. I know of it, but I couldn't quote you chapter and verse from it.
"Primary Prevention of Coronary Heart Disease: Guidance From Framingham," "Circulation."
Q. Is that an article you recognize?

A. I have read it in the past, but again I didn't look through it or know it by heart.
Q. Okay.
A. "Clinical Value of Acute Rest Technetium-99m Tetrofosmin Tomographic Myocardial Perfusion Imaging in Patients With Acute Chest Pain and Nondiagnostic Electrocardiograms."
Q. What journal is that from?

A. "Journal of the American College of Cardiology."
Q. Is that an article you recognize?
A. It's not, but the first author is one of my partners, so I guess I should.
Q. The next one.
A. The "Latest Perspectives on Cigarette Smoking and Cardiovascular Disease: The Framingham Study," "Journal of Cardiac Rehabilitation"; not familiar with it.
"Can Coronary Angiography Predict the Site of a Subsequent Myocardial Infarction in Patients With Mild-to-Moderate Coronary Artery Disease?"
Q. What journal is that from?
A. "Circulation."
Q. Are you familiar with that article?
A. Yes.

Q. The next one, please, Doctor.
A. "Can Single-Lead Computerized Electrocardiography Predict Myocardial Infarction in Young and Middleaged Men? The Tromso Study."
Q. What journal is that from?
A. That is from the "Journal of Cardiovascular Risk."
Q. Are you familiar with that article?
A. No.
Q. The next one, if you will, please, Doctor.
A. "Early Continuous ST Segment Monitoring in Unstable Angina: Prognostic Value Additional To the Clinical Characteristics and the Admission Electrocardiogram."
Q. What --
A. "Heart." It's from "Heart," H-E-A-R-T.
Q. Are you familiar with that article?
A. No, no.
Q. The next one, please, Doctor.
A. "Noninvasive Determination of Endothelium-Mediated Vasodilation As a Screening Test for Coronary Artery Disease: Pilot Study To Assess the Predictive Value in Comparison With Angina Pectoris, Exercise Electrocardiography, and Myocardial Perfusion Imaging."

Q. What journal is that?
A. "American Heart Journal"; not familiar.
Q. Okay.
A. "Family History As an Independent Risk Factor for Coronary Artery Disease," "Journal of the American College of Cardiology"; familiar.
Q. The next one, please, Doctor.
A. "Resting Electrocardiographic Abnormalities As Predictors of Coronary Events and Total Mortality Among Elderly Men," "American Journal of Medicine"; not familiar.
"Expected Gains in Life Expectancy From Various Coronary Artery Disease Risk Modifications," "Circulation"; not familiar.
"Prognostic Value of New Electrocardiographic Method for Diagnosis of Left Ventricular Hypertrophy in Essential Hypertension";

not familiar. "Journal of the American college of Cardiology."
Q. Are those all the articles, Dr. Thompson, that were provided to you?
A. You know, there is one more, and it was by William Roberts, and I think I stuck it -- it was "Atherosclerotic Risk Factors - Are There Ten, or Is There Only One?" It's from "Atherosclerosis"; and I

am familiar with it.
Q. Other than those articles you read into the record, have there been any other articles that you have received in relationship with this litigation?
A. Not to my knowledge or recollection.
Q. How much time thus far have you spent on this case?
A. 17 hours.
Q. How were you first contacted or approached by the attorneys for the tobacco company in testifying for this case?
A. I was called on the telephone.
Q. Do you remember who it was that called you?
A. It was Mr. O'Tuel.
Q. Did he tell you who he was calling on behalf of?
A. He told me -- I don't recall, actually, to tell you the truth.
Q. Do you know who Mr. O'Tuel's firm defends in this case?
A. I do now. I believe it's RJR Nabisco or RJR Tobacco.
Q. Did you have any subsequent meetings after

that phone call?
A. Yes.
Q. How many?
A. I had three, maybe four meetings in person and three teleconferences.
Q. Was Mr. O'Tuel present in all those meetings and telephone conferences?
A. No.
Q. Who did you communicate with besides Mr. O'Tuel?
A. Ms. Crooks.
Q. Was there anyone else that you have spoken to about tobacco litigation besides Mrs. Crooks and Mr. O'Tuel?
A. Christopher Olson.
Q. Anyone else besides Mr. Olson?
A. No. There is a friend that I have in Pittsburgh, where I used to live. His name is Edward Schmidt.
Q. Other than those individuals you've named, has there been any other contacts in regard to this litigation, besides the deposition you have today?
A. Well, I did discuss the wisdom of doing it with my wife.
Q. You had mentioned that you reviewed the

medical histories or files on the two class representatives of this case. Did you bring those with you today?
A. Yes.
Q. How long did you spend evaluating their file?
A. I think three hours.
Q. So it was about an hour and a half each, each patient?
A. Yes. Sorry.
Q. That's okay.
I'm going to hand you what we'll mark as Thompson number 2.
(Thompson Deposition Exhibit 2 marked for identification.)
BY MR. KLOK:
Q. Dr. Thompson, if you could just briefly look at this document and see whether or not this is a document you recognize?
A. Yes. I haven't looked all the way through.
Q. Please do, because there are other documents embedded in it.
A. Okay.
Q. Is this a document you recognize?

A. Yes.
Q. Did you help the attorneys for R.J. Reynolds put this together?
A. Well, I certainly contributed my CV.
Q. The first three pages which is entitled, "Expert Witness Disclosure," and has a caption, "Area of Expertise," and then a subject matter of expert testimony, and it goes on for three pages, ending, "Summary of Grounds for Opinion," did you have any -- have you seen this document or contributed to the formulation of this document?
A. Yes, in terms of -- I don't know what you mean, contributed to. I didn't write it personally, but I did review it and agreed with it.
Q. So as you sit here today, this is a close approximation -- or let me strike that.
This is a statement of your opinion which you are prepared to testify on in this case; is that correct?
A. Yes, yes.
Q. You have had an opportunity to review it and edit it if you wanted to, correct?
A. Yes.
Q. So as you sit here today, you agree with this; is that correct?

A. Yes.
Q. The second portion is your CV, and let's, if we could, turn to that first, is there anything on this CV as we sit here today that ought to be updated that you can remember, or is this the most current CV you now have?
A. You know, this is as of June 21, 2000, and I did update as one of your requests to September 6,

2000, and the only way I would know would be to go through almost line by line. There's not a lot different. Let me just check to see if there are new --

Q. Do you have a copy of that September 6 with you?

A. Yes.

Q. Do you mind if I can mark that as an exhibit, and we'll just save time by doing that?

A. I brought it for you.

(Thompson Deposition Exhibit 3 marked for identification.)

BY MR. KLOK:

Q. Dr. Thompson, are you a medical doctor?

A. Yes.

Q. Where did you go to medical school?

A. Tufts Medical School.

Q. What year did you graduate?

A. 1973.

Q. Are you board certified in any areas?

A. Yes.

Q. Which areas?

A. Internal medicine and cardiovascular disease; separate boards.

Q. What years did you do that?

A. Internal medicine, 1976; cardiovascular disease, 1977.

Q. Do you currently practice medicine?

A. Yes.

Q. What area do you practice medicine in?

A. I'm a cardiologist.

Q. How long have you been practicing as a cardiologist?

A. I left my fellowship training in 1978.

Q. Where do you practice as a cardiologist?

A. I practice at Hartford Hospital.

Q. Do you practice anywhere else besides Hartford Hospital?

A. No.

Q. What is the nature, Doctor, if you could, of your practice, if you could tell us?

A. What do you mean?

Q. Give an average day of the type of work that you do.

A. I would spend perhaps 60 to 70 percent of my time seeing patients who are referred in for an opinion with respect to several areas where I'm considered expert, and that is in cholesterol and heart disease risk factor management; athletes with heart disease. In general, cardiology.

I spend -- some of that 70 percent would include seeing patients on the floor who are private patients, and then I also serve on what's called the ward, W-A-R-D, service in which patients who don't have insurance are taken care of by people like me who are employed by the hospital.

I would suspect that I spend about 10 percent of my time doing administrative work, and then 20 to 25 percent of my time is spent doing

research in areas in which I'm interested.
Q. These are estimates to the best of your ability, correct?
A. Yes, and they vary from week to week, month to month, depending on my responsibilities, et cetera.
Q. How much time, for example, of a year do you estimate would you spend offering opinions as an

expert in testimony, if you can even quantify that?
A. It would be less than 1 percent. I mean, I have not offered an opinion this year, for example.
Q. So any income you receive as a result of testimony would not constitute a substantial portion of your income?
A. No.
Q. What percentage would you estimate -- let me finish the question. What percentage would you estimate of your income constitutes income from litigation testimony and review?
MS. CROOKS: Are you through with your question?
MR. KLOK: Yes.
MS. CROOKS: Object.
A. It would be less than 1 percent.
Q. Did you receive any postdoctoral training, Dr. Thompson?
A. Let me correct that. I think it would be around 2 percent, somewhere between 1 and 2 percent.
Q. Are you basing that on your income of last year?
A. Yes.
Q. Doctor, did you receive any postdoctoral

training?
A. Yes.
Q. What kind of training did you receive?
A. I received a combined program at Stanford University -- and in Connecticut you always have to say Stanford with a N, and not an M -- in cardiology, in preventive cardiology.
Q. What year did you do that?
A. I did that between 1976 and 1978.
Q. Could you explain what that type of training entailed?
A. That training entailed dealing with patients who had cholesterol problems, smoking problems, obesity, lack of exercise; things that put them at increased risk for heart disease; and it also just included general cardiology and research related to both those areas.
Q. What type of training did you receive as a cardiologist? What's the training consist of?
A. Well, in the time that I was board certified, one only needed two years, and that was just general training and taking care of patients with heart disease. I did a third year of something called cardiac catheterization, and I did that first, which was unusual in those days, but that's

where you kind of invade the body with needles and wires and tubes to measure pressures in the heart, inject dye in arteries, and things like that.

But the training of a cardiologist right now, or even in those days, is fairly complex. You learn to take care of people as people. You learn to read their electrocardiograms. You learn to read their echo cardiograms. You learn to do cardiac catheterizations and procedures. You learn to do stress tests. You learn the risks and benefits of these things, et cetera; and cardiology now has expanded from the two years that I did it to whereas many people will take five years or more. The requirement is three now.

Q. Is there anything else you want to tell me about that?

MS. CROOKS: I'll object to form. Objection.

Q. Let's move on. Doctor, are you an epidemiologist?

A. No.

Q. Are you an oncologist?

A. No.

Q. Are you a pulmonologist?

A. Nor would I want to be.

Q. I'm just asking.

Are you a pulmonologist?

A. No.

Q. Have you ever conducted any research for any of the tobacco companies?

A. Not directly, although back in the early '80s the lab I worked in had a spinoff grant from Mass General that was funded, I believe, by some sort of Nabisco heart disease prevention program. I was not the direct recipient of any of that money, but my mentor was.

Q. Your understanding of the Nabisco company was what at that time?

A. I really knew nothing about it. It's only subsequently that I have kind of learned of that.

Q. You mentioned that was money that your mentor received; is that correct?

A. Right.

Q. That wasn't money that you received, correct?

A. And it was research money. It was for projects through, we had a subgrant from Mass General.

Q. Did you do any research related to that grant money?

A. Not directly, although I was in that lab, so the benefits of it are obviously -- I mean --

Q. What was the research that was being funded with the grant? Do you remember?

A. Was not involved; don't know; didn't write grants; et cetera.

Q. Have you ever conducted research for the Council for Tobacco Research?

A. No.
Q. Do you teach?
A. Yes.
Q. Where do you teach?
A. Presently I teach at the University of Connecticut Medical School, but the way that's done is with medical students, interns and residents who rotate through Hartford Hospital. Hartford Hospital is the major teaching institution for the University of Connecticut Medical School.
Q. What classes do you teach?
A. These would be third and fourth year students who are on these rotations.
Q. Do you know what medical textbooks you use for the classes you teach?
A. I don't use medical textbooks in that instance.

Q. Are there any medical reference books that you might point your students to in teaching your course or in teaching students, medical students?
A. Of course I would have to be told what I'm pointing them toward, for what reason, because things vary in their quality. So do you have a specific question? I guess it depends on the specific issue.
Q. So there could be several books that you might refer your medical students to, depending on the problem; is that correct?
A. Certainly.
Q. Have you authored any peer reviewed publications?
A. Yes.
Q. How many, if you know?
A. According to my -- well, you have my most recent CV. I think it's 66 that are peer reviewed publications.
Q. Have any of the articles that you have written dealt with the subject of medical monitoring?
MS. CROOKS: Well, I'll object to form.
A. Is that asking about my personal research

or --
Q. Articles that you have authored, do they deal with the topic of medical monitoring?
A. Yes.
Q. Could you identify those --
A. Yes.
Q. -- from your CV, please.
A. Could I ask a question? And that is when you say medical monitoring, do you refer to exercise stress testing?
Q. Correct.
A. Five does. I have a bit of a problem because nearly all of my articles refer at least to some extent to exercise and how it relates to health and assessment of people.
For example, if you look at number 3, I didn't cite it, but it talks about the effect of arm

or leg training on maximal oxygen uptake. Maximal oxygen uptake is a measure of exercise. I will define it first tightly for you.

Number 5, number 13, number 20, number 44, number 65; and then in the reviewed articles which we didn't talk about, some of those are, as you know, peer reviewed.

Q. You're referring to the list that's titled

on your CV, "Review Articles, Book Chapters, Editorials, Position Papers"?

A. Right; and number 14, 19 deals with screening directly, as, quite frankly, does 18, 24, 27, 30.

Now, when you asked about medical monitoring programs, one of the things that I didn't point out is that a lot of these things that deal with athletes and their cardiac problems actually deal with the issue of stress testing and sudden death and myocardial infarctions; and as you can see, nearly all of those articles that are review articles, chapters and position papers deal with that. So I don't want to send you a big packet of things to read like the law firm sent me, but --

Q. No, Doctor, that's fine. I think that answers my question.

What you're saying is that to some extent your articles deal with medical monitoring, a large portion of them deal with it indirectly? Is what you're saying? Is that correct?

A. Or directly, as number 30, which addresses the guidelines for exercise testing.

Q. Right. I mean, other than the ones you identified, your other articles may possibly address

medical monitoring directly, correct?

A. Right.

Q. Have you received any awards or honors, Dr. Thompson?

A. Nowhere near enough. I was -- I actually don't list them. I won the Tufts student athlete award in 1969.

Q. I notice that you run or you ran marathons. Do you still run?

A. I trot them. At my age, you trot. You don't run.

Q. I notice in 1972 you were trying out for the U.S. Olympic team; is that correct?

A. Yes. I qualified for the U.S. Olympic trials, which is different from the team.

I received other honors. For example, I was a recipient of the Honor Award from the American College of Sports Medicine, New England chapter, things like that, but I don't list them. I don't remember those, to tell you the truth.

Q. Are there any listed or that you remember that you are particularly proud of?

A. I have four children, and their names are -- twin daughters who are folk singers named Merideth and Christina who have four CDs out, and

you are all welcome to buy them from their website; and I have two sons.

Q. Have you ever received any honors or awards involving smoking and health issues?

A. No.

Q. Have you ever received any awards or honors for public health issues?

A. No.

Q. Have you received any awards or honors that involve medical monitoring programs?

A. No.

MS. CROOKS: I'm going to object to form: Medical monitoring each time. I'll have a standing objection because I don't think that has been well defined.

MR. KLOK: Okay. Very well.

Q. Have you been a consultant, Dr. Thompson, to the Surgeon General's office or any of the Surgeon General reports on smoking and health?

A. No.

Q. Doctor, what does the term peer reviewed mean to a medical author?

A. It means that it has been submitted to a journal than sends it out to people who are -- know something about the field -- I avoided the term

expert -- who know something about the field, who evaluate the manuscript to see whether it should be accepted for publication or not.

Q. We've gone over in your CV at least a list of articles that, an extensive list that you have had peer reviewed, correct?

A. Yes.

Q. Why is the peer review process important, Dr. Thompson?

A. It often provides some balance to what's published, so that something is neither too extreme one way or the other, and it provides a check on the quality of the article, and it lets the journal editor, who may not be expert in that area, make a reasonable decision as to whether the paper should be published or not.

Q. Other than this case, have you ever offered testimony for tobacco companies in any other litigation?

A. No.

Q. Do you smoke, Dr. Thompson?

A. No.

Q. Did you ever smoke?

A. No. Oh, five or six cigarettes which I flushed down the toilet before my father caught me.

They don't flush well.

Q. How old were you then?

A. I think probably 13.

Q. Do you remember what brand they were?

A. No. They were my uncle's. Maybe Chesterfields. I don't know.

Q. Doctor, I'm going to hand you the next exhibit, please. I'll first give it to the reporter

so she can mark it as exhibit next and have you look at it and see if you recognize it.

(Thompson Deposition Exhibit 4 marked for identification.)

A. This looks like the website for Hartford Hospital.

BY MR. KLOK:

Q. If you could, just look through it and read the next few pages and see if it is something you're familiar with.

A. Okay. It's entitled --

Q. You don't need to read it out loud. Just review it quietly.

A. You want me just to read, "How To Quit"?

Q. I have some questions. Let me know when you've finished.

A. I've finished the second page. I've

finished the second page. Do you want me to read the third page?

Q. Yes. Just look through the whole document, if you would, Doctor, and make sure that you are familiar with it.

A. I've read both of them.

Q. Is this a document that you identified as the web page of the Hartford Hospital?

A. Um-hum.

MS. CROOKS: I object; form.

Q. You said um-hum. You meant yes, Doctor?

A. Yes.

Q. Following that, there are a few pages, one captioned, "Effects on Your Health"; is that correct?

A. I only have, "How To Quit" and, "Lung Cancer."

Q. I think we have different copies.

(Discussion off the record.)

(Thompson Deposition Exhibit 5 marked for identification.)

BY MR. KLOK:

Q. Doctor, I just handed you the complete version of the exhibit, Thompson 4?

MS. CROOKS: Do you have one for us?

MR. KLOK: He has the only copy. It may have some pages you didn't see.

Q. If you could just review that, please.

A. Okay.

Q. If you could, Doctor, that document which is marked as Thompson 4, you identified as it being the web page of the Hartford Hospital; is that correct?

MS. CROOKS: Object; form.

A. I think what I said is it looks like the web page of Hartford Hospital. I've got to honestly say that I have not read it before, but it looks like the web page of Hartford Hospital. I recognize the front page as being that logo.

Q. The subsequent pages have, I think starting with the first one -- what's the first captioned page?

A. "Effects on Your Health."
Q. The "Effects on Your Health" speaks about the effects on your health of smoking and cigarettes; is that correct?
A. Yes.
Q. And the next page, what's the caption of that?
A. "How to Quit."

Q. These are what seems to be the hospital recommendations on how to quit smoking; is that correct?
MS. CROOKS: Object; form.
A. That's what you asked me, if that's what they seem to be. That's what they seem to be.
Q. The next page is captioned -- if you would?
A. "Lung Cancer."
Q. I believe if you read the second line under, "Lung Cancer," "The most common risk factor for lung cancer is smoking." Do you see that?
A. Yes.
Q. It specifically says, "due to the harmful carcinogens found in tobacco smoke"?
A. Yes.
Q. And then the last page, I don't know if it's the last page or second to last page, if you could read the next page?
A. "Secondhand Smoke."
Q. That basically talks about the risk factors associated with secondhand smoke; is that correct?
A. Yes.
MS. CROOKS: Object; form.

Q. Are you aware whether or not the Hartford Hospital has a smoking cessation program?
A. Yes.
Q. Have you been involved in that smoking cessation program?
A. Absolutely.
Q. Could you please tell me what that smoking cessation program involves.
A. Right. We have a psychologist named Ellen Dornelas who has organized a smoking cessation program for our patients with heart disease and for those without heart disease that involves counseling, nicotine replacement, and use of other medications such as Zyban or Welbutrin to help people stop smoking. I speak at that and counsel people strongly to stop smoking.
Q. When you speak at it, what particular topic do you talk about, Dr. Thompson?
A. I talk about health in general and the risk factors associated with cigarette smoking.
Q. Do you refer patients to that program?
A. It's actually in my department.
Q. I think I asked this, but I'm not sure. Did you help frame that program at Hartford Hospital?

A. Only indirectly, in that I helped the woman who runs the program in that way; but I certainly don't tell her how to get people to quit, although I'm very interested in getting people to quit.
Q. How much time do you dedicate in that program?
A. It would be an infinitesimal amount, but any time they need a prescription and need a physician to write it, or if they need to see some patients who may have a complaint, or decision as to whether somebody should be on a medication, I would do that; and then once every six-week session I'll meet with the people and try to help motivate them to stop smoking.
Q. Do you agree that cigarette smoking is an addictive behavior?
A. I'm really not an expert in addiction. I really am not. I do know that it's very hard for lots of people to quit, but that 45 million people plus have quit, so I think people can quit.
Q. Do you think that all cigarettes contain sufficient nicotine to create and sustain an addiction?
MS. CROOKS: Object.

A. I really don't -- sorry.
Q. Your answer? I wasn't sure --
MS. CROOKS: I just object to form.
A. I really don't know the answer to that.
Q. Why is that, Doctor?
A. I just don't -- it's not an area that I consider myself expert in. I consider myself an expert in cardiology and kind of stress testing and EKGs and that sort of stuff, the wisdom of that, but I don't consider myself an addiction expert.
Q. Do you have an opinion about whether or not nicotine is addictive?
A. I guess I know it's defined, it's defined by groups, and so I would rely on these groups who are smarter than I in terms of defining addiction. It's clearly been a changed definition over the past few years, and I haven't stayed up with it. I certainly recognize that people have a very difficult time stopping smoking.
Q. In your opinion, Dr. Thompson, do you believe that cigarette smoking causes disease?
A. You have to be specific for me. I'm much more conversant in terms of cardiovascular disease, and I think it also depends a fair amount on what disease one might talk about.

Q. So in your opinion, do you think cigarette smoking causes cardiovascular disease?
A. I think it greatly contributes to the development of coronary artery disease, but I've got to point out that science is actually a moving target, and right now we are beginning to debate what causes heart disease, and there's lots of interest in inflammation, various microorganisms.

So when you say cause, there's no doubt in my mind that cigarette smoking accelerates the development.
So I don't want to get into kind of a semantic thing. I certainly encourage people to stop smoking. I tell them they absolutely must stop smoking.
Q. Are there any other cardiovascular diseases, to your knowledge, or in your opinion, that are caused by smoking?
MS. CROOKS: Object to form.
A. Again, you know, I think we have to -- and I'm not trying to be evasive. I think that "cause" is for me a difficult term because right now we cardiologists are debating whether viruses or even some infectious agents -- in fact, there are trials going on of antibiotics to see if they prevent heart disease. So when you say cause, it's an accelerant

of vascular disease in general, and that vascular disease includes vascular disease of the coronary arteries, vascular diseases of the cerebral arteries, vascular disease of the legs, peripheral vascular disease. And then you cannot separate, you know, atherosclerosis from other effects on clotting and things like that.
So cigarette smoking is clearly an accelerant of this process.
Q. How much of an accelerant is it?
A. I don't know the answer to that.
Q. Would you consider cigarette smoking the major accelerant?
A. I think, as we understand it now, that cholesterol would be the major issue because there are plenty of populations where cigarette smoking is high, but coronary disease is low.
Don't misinterpret me. That doesn't mean that I don't want everybody to stop smoking. It's just that from my point of view, maybe with a bias of being a lipid person, that lipids are very, very important in the development of coronary disease. You generally don't get it with at least some modest elevation in cholesterol levels. Atherosclerotic disease I'm talking about.

There are some experts, as you know, that argue that there only ought to be one risk factor, and that ought to be cholesterol. I disagree with that because clearly cigarette smoking accelerates the process.
Q. Is a person who has a history of smoking cigarettes at a significantly increased risk of contracting serious latent diseases above that of a person who does not have a history of smoking cigarettes?
A. Yes.
MS. CROOKS: Object to form.
Q. On what do you base that opinion?
A. General knowledge.
Q. When you say general knowledge, are you talking about your general medical knowledge?
A. Yes; but also what I read in the newspaper

every day, what I read on cigarette packages. I mean, one would have to have had their head in the sand over the past 50 years.
Q. Do you know, Doctor, when the warning labels came on cigarette packages --
A. No, I don't.
Q. -- what year?
Do you know when the first Surgeon

General's report on smoking and health was issued?
A. 1964.
Q. Do you remember what they taught you in medical school about smoking?
MS. CROOKS: Object; form.
A. No, I don't.
Q. Do you remember if there were ever any discussions on smoking and health in any of your medical school classes?
A. I don't think there was ever a lecture, "Smoking and Health," for example; but I'm certain there were plenty of, you know, indirect discussions of it.
Q. Do you remember whether or not it was still an issue of, it was considered an issue of scientific debate whether smoking caused or accelerated or was a risk factor for disease?
MS. CROOKS: Object to form.
Give me an opportunity to object before you answer, Doctor.
A. Okay. I don't think there's been much debate about that in the medical profession since the '50s, that it's an accelerant, and clearly since 1964 I don't think there's been a lot of debate in the public as well.

Q. Would you agree with the statement that cigarette smoking causes 85 to 90 percent of the lung cancer that occurs in the United States?
A. I cannot answer that. I really am not an expert. I don't know the answer to that. I think it would depend partly on whether it's primary or secondary. There are a lot of issues I couldn't address.
Q. Are you familiar with the 1989 Surgeon General's report?
A. No.
Q. Have you read any of the Surgeon General's reports?
A. I've read parts of some of them.
Q. Let me read you the title and see if that refreshes your memory. The 1989 Surgeon General's report is entitled, "Reducing the Health Consequences of Smoking: 25 Years of Progress, A Report of the Surgeon General, 1989."
Does that ring a bell?
A. It really does not ring a bell.
Q. Doctor, are you familiar with the CPS-2 data?
A. I don't even know what it stands for.
Q. Doctor, whose medical records have you

reviewed in preparation for this deposition in this case?
A. I reviewed Christine Blankenship's and Mae Sibo's.
Q. Do you have an opinion as to whether or not Christine Blankenship is at an increased risk of contracting a smoking-related disease as compared to persons who never smoked?
A. I think that anyone who smokes is at potentially increased risk, depending on how much they smoked, of contracting a disease compared to someone who doesn't smoke. That's why I encourage people to stop smoking.
Q. Would you agree with me, Doctor, that just because a person may have multiple risk factors, it does not change the fact that smoking is still a risk factor?
A. Smoking is still a risk factor, especially when people have additional risk factors.
Excuse me. You did ask about vascular disease, right?
Q. I --
A. Because that's where I feel -- let me answer this question. A person is --
Q. Let's try it this way. I mean, your

answer was referring to vascular disease; is that correct, Doctor?
A. Yes.
Q. You were not talking about other diseases, were you?
A. I was not.
Q. Is that because you're qualified as a doctor in cardiovascular disease?
A. Right.
Q. You're not qualified to comment on pulmonary disease, for example?
A. I don't consider myself an expert in pulmonary disease or lung cancer, et cetera.
Q. So when you're providing answers, we are talking about disease, you're restricting it to the area of your expertise, which is cardiovascular disease; is that correct?
A. Unless specified.
Q. Do you plan to testify about disease in general beyond cardiovascular disease in this case?
A. I guess it depends on what you ask me.
Q. Would you consider yourself an expert in those areas outside of cardiovascular disease?
A. I think you --
MS. CROOKS: Object to form.

A. You can get better experts than I in areas that relate to other issues.
Q. Are there any circumstances that you know of where a person who smokes will not be at an increased risk of getting cardiovascular disease?
A. It's a complex issue because everybody that smokes is at potentially increased risk. There is what we call relative risk and then absolute

risk, and so what I don't know is the specifics.
Q. To your knowledge, Doctor, are there any minimum levels of safe -- minimum safe levels of smoking where someone is not put at any increased risk?
A. I'm not an expert in that. I can't tell you. I try to get everybody to stop smoking, but I don't know the epidemiology as to when risk accrues.
Q. Does a smoker with a five-pack-year history have an increased risk of contracting cardiovascular disease?
A. I don't know the answer to that from an epidemiologic point of view. From a -- I do have a sense of it from an absolute point of view, and that is that if someone only had five pack-years of smoking, that they may be at increased risk versus another person -- they may be -- but that absolute

risk would be trivial, meaning that you would need a ton of people to document that increased risk. A ton.
Q. Doctor, assume for this question that an individual has no other risk factors other than a five-pack-year smoking history. Would they have an increased risk of contracting lung cancer?
A. Not a --
MS. CROOKS: Object.
You can answer.
Of lung cancer?
MR. KLOK: Yes.
A. I don't consider myself an expert in that.
Q. The same question for cardiovascular disease?
A. Repeat the question, please.
Q. Assume that an individual has no other risk factors other than a five pack-year smoking history. Would they have an increased risk of contracting cardiovascular disease?
A. I actually don't know the answer as to when you look at epidemiologic data one can say that there actually is a step-up in the relative risk.
Q. Does a smoker with a five pack-year history have an increased risk of contracting

chronic obstructive pulmonary disorder?
A. I don't know the answer to that. I don't consider myself an expert in chronic pulmonary disease.
Q. Do you agree that before a medical monitoring program can be set up a person must have some exposure to a known risk factor?
MS. CROOKS: I'll object to form.
A. You know, I don't feel capable of talking about medical monitoring programs in general. I can talk about exercise stress testing and baseline EKGs.
Q. Doctor, do you have any opinion as to whether Ms. Sibo is at an increased risk of contracting a smoking-related disease as compared to persons who never smoked?
MS. CROOKS: Object to form.

A. In an area that I know something about, I do believe she's at increased risk of contracting coronary artery disease, vascular disease.
Q. Why is that, Doctor?
A. Because she has risk factors for vascular disease.
Q. What risk factors are those?
A. She is a cigarette smoker. Her father is

reported in the medical record as having a massive MI, and she has had periods of anxiety and depression which are increasingly recognized as risk factors for heart disease.
Q. Are there any other reasons besides those you've named?
A. Well, she also has presently an abnormal EKG, and by echo cardiogram she has an increased right ventricle. The latter would not be a risk factor for coronary artery disease per se, but for heart disease; and the same with the EKG.
Q. Did you identify any risk factors that put Ms. Christine Blankenship at risk for contracting smoking-related disease?
A. Yes.
Q. What were those risk factors?
A. Well, her father had vascular disease in that he had a stroke, and her mother was reported to have a heart attack. So she has a bad family history; as well as a brother had MI. She's been hypertensive, she has an elevated cholesterol level, she's overweight, and she also has had some periods of depression.
Q. Does Ms. Blankenship smoke?
A. Yes.

Q. Would you consider that a risk factor?
A. Yes. I apologize for neglecting to mention it. Kind of an important oversight.
Q. You mentioned it's an important oversight, Dr. Thompson. Why do you say that? Why is smoking an important oversight?
A. Because we are here on a tobacco-related case. That's pretty obvious.
Q. Would you consider smoking a significant risk factor in cardiovascular disease?
A. Yes.
MS. CROOKS: Object to form.
A. Yes, absolutely.
Q. Doctor you are familiar with the "Guide To Clinical preventive Services" from the U.S. Preventive Services Task Force, second edition?
A. Which year was that?
Q. I'll tell you in a second. 1989.
A. I think the one that I recall is 1988. So it might have been a little different of a publication, and I'm not familiar with it in its entirety. I'm familiar with it with respect to the recommendations for exercise stress testing.
(Thompson Deposition Exhibit 6 marked for identification.)

BY MR. KLOK:
Q. Doctor, I'm going to read to you a section, and let's see if I can point you to it. It's on page XLI, which is the third page, I think. It's the second paragraph, and it reads, see if you can follow along with me:
"The second criterion for selecting preventive services for review was that the maneuver had to be performed in the clinical setting. Only those preventive services that would be carried out by clinicians in the context of routine health care were examined. Findings should not be extrapolated to preventive interventions performed in other settings. Screening tests are evaluated in terms of their effectiveness when performed during the clinical encounter, i.e. case finding. Screening tests performed solely at schools, work sites, health fairs, and other community locations are generally outside the scope of this report. Also, preventive interventions implemented outside the clinical setting, e.g., health and safety legislation, mandatory screening, community health promotion, are not specifically evaluated, although clinicians can play an important role in promoting such programs and in encouraging the participation

of their patients. References to these types of interventions are made occasionally in sections of this book."
Do you see that portion that I just read?
A. Yes, yes.
Q. I'm going to take this line by line. Let's start.
MS. CROOKS: First of all, I want to object on the record for asking medical questions on a couple of pages from a book that he clearly cannot put in context.
MR. KLOK: At this point it's only a paragraph, not a couple of pages; but let's go forward.
MS. CROOKS: A paragraph. They have been worse.
Q. Doctor, if we could, let's look at the first section of that paragraph where it says the second criterion for selecting preventive services for review was that the maneuver had to be performed in the clinical setting.
Do you agree that this statement means that the methodology examined was limited to only those performed in the clinical setting?
MS. CROOKS: Objection.

A. Can you repeat the question for me?
Q. Sure. Again, taking the portion at the beginning of the paragraph that says, "The second criterion for selecting preventive services for review was that the maneuver had to be performed in the clinical setting," do you agree that this statement means that the methodology examined was limited to only those performed in the clinical

setting?
MS. CROOKS: Objection.
A. I think so.
Q. Okay. Is it because the question is not clear, or --
A. It's because I really -- I don't know exactly what the whole thing is. I mean, I have an idea of what it is.
For example, you said did they examine things outside the clinical setting. They may have and decided not to include them.
It seems to me that what they are saying is that they are looking at testing that's been done in clinical settings, but I'm a little bit guessing. I'm just trying to be cooperative.
Q. Is this a document, as we read through, I guess, that paragraph, is this something that you

recognize?
A. The only part of it I recognize is that I did look up in it not so long ago the part that dealt with stress testing; and even then I did not read every little word of it, but took the summary of what they were recommending.
Q. As you sit here today, do you remember what that summary or recommendation was?
A. The summary --
MS. CROOKS: Do you remember?
A. Let me say that the recollection I have was that the author was Sax, S-A-X, 1988, not 1989, and that was a task force looking at the value of exercise testing in asymptomatic individuals, and they thought it was not justified because of the low yield and high rate of false positives. Now, that is from memory.
Q. But you did not consult the later edition which is the 1989 edition; is that correct?
A. I actually think that these people would not have gone through that arduous task twice in two years, so I think either I got an early version or you got a summary which looks like it's from a book because it says Williams and Wilkins. So it may be different, it may be the same. I can't tell you.

Q. Is your understanding, at least the limited understanding you have, based on reading the portion that dealt -- that you just described on the record that dealt with, was it cardiovascular testing? Is that correct? Was it your understanding that those preventive services would be carried out by clinicians in the context of routine health care?
MS. CROOKS: Object; form.
Q. If you remember, Doctor.
A. I'm confused on the question. Try me again.
Q. You had earlier described that you had only read a portion of this report, the 1988 version, in which it dealt with cardiovascular exercise, correct?
A. Yes.

Q. Is it your recollection that those preventive services would be carried out by clinicians in the context of routine health care?
MS. CROOKS: Object; form.
A. Yes, that's my understanding, that this was a guide for clinicians performing preventive services.
Q. Do you understand, Dr. Thompson, that in

this case the plaintiffs are asking the court to set up a medical monitoring program?
MS. CROOKS: Object to form.
A. Yes.
Q. Do you understand, Dr. Thompson, that as a part of the plaintiffs' proposed medical monitoring program, plaintiffs are asking that certain tests or evaluations or medical tests be performed on class members who meet the criteria of the class definition and who fall within the guidelines for receiving such testing?
MS. CROOKS: Object to form.
A. That's a long question.
Q. You want me to go again?
A. Nice and slow.
Q. Dr. Thompson, is it your understanding that the plaintiffs' proposed medical monitoring program is asking that certain tests or evaluations or medical tests be performed on class members who meet the criteria of the class definition and who fall within the guidelines for receiving such testing?
MS. CROOKS: Object to form.
A. I understand that they are proposing that certain patients receive testing.

Q. Do you have any information, Dr. Thompson, that leads you to believe that the test Dr. Burns is recommending could only be carried out by clinicians in the context of routine health care?
MS. CROOKS: Object to form.
A. I can tell you that exercise stress testing right now would not get reimbursed by Medicare unless a physician was present in the room, not just the facility.
I'm sorry, I have to have you repeat the question again.
(Question read.)
MS. CROOKS: I object to form.
A. You know, I don't understand the question. Here is why: When you say routine health care, this is not routine health care because routine health care, even for this group of patients, wouldn't recommend such testing. Routine health care would not recommend that the decisions as to who gets tested be done by a court. Even though the court may have great wisdom, they would think that the testing should be done in an individual manner, depending on that patient's risk factors for disease, with someone with some training performing the test, with someone with some training giving the

person the bad or the good news, with someone with some training and stature being sure to make sure they reinforce the importance of stopping smoking.

So I have lots of reasons to think that it wouldn't be a good idea to have this done at the Sheraton at Bradley Airport unless I were there.

Q. Have you read Dr. Burns' proposed medical monitoring plans?

MS. CROOKS: Object to form. I want to put this objection on the record because, as I understand it, it has changed significantly throughout the course of the litigation, and so I would request that you, if you are going to ask him about Burns' medical monitoring program, you let us know what proposal it is of Dr. Burns that you are talking about.

Q. Dr. Thompson, have you read any materials from Dr. Burns in relationship to this case?

A. Yes.

Q. Have you read his proposed medical monitoring proposal?

MS. CROOKS: Object to form.

A. I've read one, and I'm trying to find it so I can tell you which one.

Q. While you're looking, have you reviewed

any deposition testimony by Dr. Burns in this case?

A. No. I have a document that I was given that says, "Revised Report of David M. Burns." It does not have a date on it so that I can tell you exactly -- at least I can't -- oh, 2/3/00 is the date it was signed; two, slash, 3, slash, zero zero.

Q. Are there any other materials from Dr. Burns that you have in your possession?

A. No, not that I'm aware of.

MR. KLOK: Why don't we take a five-minute break at this point.

(Recess: 4:52 to 5:01 p.m.)

(In the telephonic presence of Mr. Dascoli and the absence of Mr. Davenport.)

BY MR, KLOK:

Q. Doctor, are you aware that in this case the court will ultimately determine what sort of medical monitoring program will be provided to the class members, if any?

MS. CROOKS: Object to form.

A. I have been advised of that.

Q. In your opinion, Doctor, would a medical monitoring program ever be beneficial in any circumstance?

MS. CROOKS: Object to form.

A. I really can't answer the question "ever" because that's just a guarantee you are going to be wrong. I can address specifics of this medical monitoring, especially as they relate to EKGs and stress tests. I think I've said that.

Q. If you could describe under what circumstances you think this medical monitoring

program may be beneficial.
MS. CROOKS: Object to form; and would you please tell him what part of this medical monitoring program and what this medical monitoring program is that you are specifically asking him about.
Q. Doctor, do you understand --
MS. CROOKS: I have a continuing objection to that, and we don't know what you're talking about, and I think our expert witnesses are entitled to know what you are talking about.
Q. Doctor, do you understand my question?
A. I understand your question, but I really can't provide an answer, and that's because I need to know exactly what parts of the medical monitoring you're talking about. I'm not an expert in all areas of medical monitoring.

Q. Have you ever recommended a medical monitoring program for any individual?
MS. CROOKS: Object to form.
A. Tell me what -- I'm sorry to ask a question in return, but I need to know what medical monitoring you are -- for example, do I measure blood pressure? Yes.
Q. When dealing with cardiovascular disease, have you ever recommended a medical monitoring program for an individual?
MS. CROOKS: Object to form.
A. I really cannot answer because I don't know what you're talking about in terms of a medical monitoring program.
Q. Have you ever recommended a medical monitoring program for a population?
MS. CROOKS: Object to form.
A. No; and most experts don't.
Q. Have you ever designed a medical monitoring program of any sort?
MS. CROOKS: Object to form.
A. No.
Q. Is it your opinion that no screening test has been shown to be beneficial in the detection of cardiovascular disease?

A. No screening test? No, that's not my opinion.
Q. What screening test, if any, is beneficial for showing cardiovascular disease?
A. There is some evidence that electron beam computerized tomography may be, but that's preliminary. The American Heart Association has advised against it until more data is available.
Q. Any other tests?
A. Cholesterol measurements, blood pressure are not useful in defining or detecting coronary artery disease, but are useful in helping to identify people that could be benefited by -- could benefit from preventive interventions; but they are not addressed in this proposal.
Q. Are there any other tests that you would think are useful for screening out cardiovascular

disease?
MS. CROOKS: Objection to form.
A. You know, I'm much better at a specific test than I am the global universe. I tend to be an expert in or am considered an expert in exercise stress testing because I sat on that committee, know a lot about it, write about it, and things like EKGs.

Q. Dr. Thompson, are you aware of what criteria is used for a breast cancer screening?
A. No.
Q. Are you familiar with recommendations for screening teachers and health care workers for TB?
A. In truth, I am not. Did you say health care workers?
Q. Correct.
A. I'm sorry.
Q. Health care workers and teachers for TB.
A. The answer is no for both of them. I can tell you about health care workers.
Q. Are you aware that such screening takes place in the U.S.?
A. Yes, in health care workers.
Q. Tell me how it takes place for health workers.
A. I can only talk from personal experience. I'm required to get a TB test when my secretary tells me it's time to get one.
Q. Is it your opinion that when you get screened for TB that you should have a physician evaluate whether you need it or not?
MS. CROOKS: Object to form.
A. Physicians have, I would assume, decided

that this is what's necessary for health care workers, at least at Hartford Hospital, which is an inner city hospital with a fairly large immigrant population. I actually don't know what the universal recommendation is.
Q. Do you have any knowledge as to whether or not Hartford had any physicians evaluate whether a TB screening test should occur or not?
A. No direct knowledge.
Q. Are you familiar with the recommendations for vision screening for children?
MS. CROOKS: Object to form.
A. No.
Q. In forming your opinion as reflected in your expert disclosure, and I believe -- I'm not sure what number that is. Is it number 2, I believe?
MS. CROOKS: Yes.
Q. It's Thompson 2. In forming your opinion as reflected in your expert disclosure regarding plaintiffs' proposed medical monitoring program, did you utilize any sort of decision-making model?
A. No.
MS. CROOKS: Object to form.
Q. Are you familiar with an article by a

David M. Eddy entitled, "Common Screening Tests"?
A. No.
Q. At the Hartford Hospital is it standard policy to not order medical tests if they are not covered by insurance?
MS. CROOKS: Object to form.
A. No, it's not the policy.
Q. What's the policy at the Hartford Hospital?
A. The patients get care they need.
Q. So at the Hartford Hospital lack of insurance does not constrain ordering tests?
A. No.
Q. When you see patients, are they typically symptomatic?
MS. CROOKS: Object.
A. Some are, some aren't.
Q. Does the Hartford Hospital have a standard practice on tests to order in smokers who are asymptomatic?
A. Not that I'm aware of. It would be an individual physician decision.
Q. What is a myocardial infarction?
A. A myocardial infarction is death of a certain part of the heart from inadequate blood

supply.
Q. Does identifying and diagnosing cardiovascular disease early and intervening prolong a patient's life?
MS. CROOKS: Object to form.
A. Yes.
Q. Does identifying and diagnosing cardiovascular disease early and intervening prolong a patient's life if that person has had previous heart attacks?
A. Can you repeat the question again.
Q. Yes. Does identifying and diagnosing cardiovascular disease early and intervening prolong a patient's life if that person has had previous heart attacks?
A. If they have had a previous heart attack it's already been identified that they have disease.
Q. Is that always true?
A. You cannot have a heart attack without having disease. Always true.
Q. Is it always true that a heart attack is identified by a physician before a patient visits you?
A. No.
Q. In those cases, does identifying and

diagnosing cardiovascular disease prolong a patient's life if that person has had previous heart attacks?
MS. CROOKS: Object to form.
A. Can you repeat it again for me.
Q. Yes. I had just asked you in cases where there is an unidentified heart attack whether or not, when those patients come to you and you provide

early intervention, whether or not that can prolong that patient's life.
A. To be honest, that hasn't been directly studied. What we do know is that if patients have diagnosed, known disease, that they benefit from having their risk factors, like cigarette smoking, cholesterol levels, blood pressure, treated and lowered.
Q. On what do you base your opinion that they benefit by making those changes?
A. I base it both on published literature and knowledge of clinical opinion, national clinical opinion.
Q. Do doctors use electrocardiograms to assist in their diagnosis of myocardial infarction?
A. Yes.
Q. Isn't it true, Dr. Thompson, that the

"Guide To Clinical preventive Services" report of the U.S. preventive Services Task Force reports a recommendation for screening by electrocardiography of at-risk populations?
MS. CROOKS: Object; form.
A. Don't know the answer to that.
Q. Is that because you're not familiar with that guide?
A. Right. I haven't read that section of that guide.
Q. Are you familiar with the American College of Sports Medicine recommending exercise ECG testing for men over age 40 and women over age 50 and other asymptomatic persons with multiple cardiac risk factors prior to beginning a rigorous exercise program?
A. Yes.
Q. Do you agree or disagree with that limited recommendation?
A. Disagree.
Q. How so?
A. I think that it is a waste of time, money, effort, and an impediment to patients starting exercise programs that have very low risk. That's from our studies and from other people who have

looked at the risks of exercise.
Also, exercise stress tests do not identify who is going to drop dead or who is going to get a heart attack. They identify who is going to develop chest discomfort, predictive angina.
So a lot of experts, including the group that I sat on, the American Heart Association, and the American College of Cardiology, question whether there's a role at all for stress tests and screening except in patients who are being evaluated with disease.
Q. Is this something you are prepared to testify about in this case?
A. Yes, of course.
Q. Is it true that the ACC and the AHA recognize that the exercise ECG is frequently used -- strike that.

Dr. Thompson, is it true that the ACC and the AHA recognize that the exercise ECG is frequently used to screen asymptomatic persons in some high risk groups, but concluded that there is divergence of opinions with respect to its usefulness? The ACP does not recommend exercise testing with ECG or thallium -- I hope I can pronounce this -- cymography as a routine screening

procedure in asymptomatic adults?

MS. CROOKS: Object to form.

A. You are going to have to take me through it again.

Q. I'll do it.

Is it true that the ACC and the AHA recognize that the exercise ECG is frequently used to screen asymptomatic persons in some high risk groups, but concluded there is a divergence of opinion with respect to its usefulness?

A. Yes.

Q. Is it also true that the ACP does not recommend exercise testing with ECG or thallium cymography as a routine screening procedure in asymptomatic adults?

A. I was not on the committee that was part of the ACP. I was on the committee that was part of the ACC. So I can't comment on what the ACP recommends or thinks; but I was part of the ACC.

Q. Tell me your understanding of how, or at least your -- no, strike that.

Tell me your opinion about the ACC's opinion.

A. I think it was throwing the dogs a bone in that all of us, or nearly all of us, on that

committee thought that the use of exercise testing, even in high risk groups, was not worthwhile; but we thought it was very difficult for an organization that represents cardiologists to come across and say that we didn't think cardiologists should be doing exercise stress testing in that situation, because, as you read to me, we recognize that it was frequently done. Changes in such practices often require time, and so we made the first step as a committee.

Q. Do you have any opinion about the ACP's recommendation?

A. As I understand the American College of Physicians, they don't recommend that such stress testing should be done, and I think that makes excellent sense, for a multitude of reasons.

Q. Could you tell me some of those reasons, Doctor.

A. Depending on who you stress, the rate of false positives can be quite high, which then means in the United States that those patients who are falsely positive, in other words, they have no disease, are subjected to not only the anxiety of being told that they have disease when they don't, but to referrals to cardiologists, and then the risk

of invasive procedures designed to exclude the presence of disease.

Sometimes disease is actually detected, but would be better off left alone; but in the United States it is what we call the ocular catheter reflex, which is if you see it, you stick a balloon catheter in it and dilate it up.

An increasing number of studies suggest that the detection and invasion of those lesions when they are asymptomatic or mildly symptomatic may not reduce the risk of heart disease, but actually increase the risk. So false positives, with the negative side effects of that.

Q. Are there any other reasons that you can think of or that you know of?

A. It does not predict, stress testing does not predict the things you worry about. It's not a good predictor of who is going to get a heart attack and who is going to die suddenly. It's a good predictor of who is going to get chest discomfort, known as angina, and the reason for that is that if you have a narrowing that's there and not hurting you, it's a stimulus for the body to adapt to it and to do its own bypass surgery. That bypass surgery may be superior, that gradual development of

collaterals, vessels around the narrowing, may be superior to somebody with a balloon opening it up suddenly or somebody with a surgeon bypassing it.

So I actually think that there is risk to willy-nilly screening, monitoring; but I'm not alone in that opinion. That's the opinion, as I recall it from sitting in discussions, of the American College of Cardiology and the American Heart Association, and it makes infinite sense if you understand the disease.

Q. Does the Blankenship class involve a high risk population group for cardiovascular disease?

MS. CROOKS: Object to form.

A. Does the Blankenship -- say it again for me.

Q. Does the Blankenship class involve a high risk population group for cardiovascular disease?

MS. CROOKS: Object to form.

A. I, unfortunately, am a clinical cardiologist and need to deal with Mrs. Blankenship herself. She has risk factors for heart disease, so she's at increased risk of developing heart disease, as would anyone who has multiple risk factors as does she.

Q. Would it be true, absent all other risk

factors, that smokers are at high degree of risk for cardiovascular disease?

A. You know, absent all other risk factors, the data as I understand it is that absent, for example, cholesterol levels -- and that's a key issue here -- is that they are not at increased risk of heart disease or vascular disease.

Q. So would you agree that smokers with

abnormally high cholesterol levels are especially at risk, as opposed to people who don't smoke with high cholesterol levels --

MS. CROOKS: Object.

Q. -- for contracting cardiovascular disease?

A. Someone who has both smoking and cholesterol has increased risk versus someone who does not smoke; absolutely.

Q. Is it your opinion that no screening test has been shown to be beneficial or effective in the detection and treatment of cardiovascular disease?

MS. CROOKS: Object to the form.

A. I think we dealt with this.

MS. CROOKS: I think it's been asked and answered.

Q. If you could, Doctor.

A. Repeat it for me.

Q. Is it your opinion that no screening test has been shown to be beneficial or effective in the detection and treatment of cardiovascular disease?

MS. CROOKS: Object to form.

A. Well, it's a very tough question for me to answer, and the reason is that when you say no test, I'm always challenged because there's always something. When you say the detection and treatment, it's two things.

There are lots of tests that are very valuable in the treatment of coronary artery disease. I wouldn't know what to do with my patients with coronary artery disease without certain tests to define the extent of disease, cardiac catheterization or stuff like that. So, no, it's not my understanding.

Q. Is it your opinion that medical monitoring programs may do more harm than good because of potential negative effects on the population if the screening tests are inadequate?

MS. CROOKS: Object to form.

A. You know, the problem with saying medical monitoring tests to me, Rhett, is that I'm not, like, an expert in all monitoring tests. I would like to talk about electrocardiograms and stress

tests because I know a lot about them.

Q. Well, let me rephrase that question, then. Is it your opinion that an electrocardiogram test and exercise stress test may do more harm than good because of possible negative effects on the population if the screening tests are negative?

MS. CROOKS: Object to form.

A. I think that screening tests with electrocardiography and stress tests have generally revealed in people who are asymptomatic or at only modest -- well, some area of defined risk, they have done more harm than good, yes.

Let me correct that. I don't think it's been proved that they have done more harm than good because it hasn't definitely been studied. In other words, I can't say to you that I can absolutely prove there will be more harm than good, but you

also can't say to me that you absolutely proved they will do more benefit than harm.

It would be the opinion of myself and people like the American College of Cardiology, American Heart Association group on stress testing, that they would do more harm than good. So I think the onus falls on you to prove that they do more benefit because it makes all the sense in the world

that they do more harm, all the sense in the world.

Q. Do you believe that the less people know, the better off they are?

A. Absolutely not.

Q. So if screening informs the patient, even though it may not improve their prognosis, should the screening be done to give the patient a chance to know of his condition?

MS. CROOKS: Object to form.

A. Depends on the screening, depends on who is doing the screening, depends on how it's presented to the patient, depends on the wisdom of the physician, depends whether it's administered by the legal -- no matter how wise they may be -- versus medical community. Depends on many things.

Q. So can you foresee a circumstance where even if there's no prognostic benefit, but there is a benefit in terms of a patient having knowledge of his condition under certain circumstances, would you consider that beneficial to the patient?

MS. CROOKS: Object to the form; speculative.

A. You have to introduce me to that patient so that I can talk to them and see where they are coming from. Some patients informed of a bad result

will say, "Screw it, I'm going to -- that's life." Other people informed of a bad result will be frightened to death. So these things require somebody interacting with that individual, rather than a blanket sort of recommendation in this instance with these issues.

Now, there may be other areas of monitoring that I'm not an expert in where it's very useful.

Q. Do you know how many individuals would be screened in West Virginia if the court granted the medical monitoring class?

MS. CROOKS: Objection.

A. No. It's been told to me at some point in passing, but it's not a number that registered with me; and I think one of the problems is that class, or who is going to get this, has changed somewhat, and I'm not certain exactly who that would be.

Quite frankly, it does not make a whole big deal of difference to me because in general more screening for exercise stress testing is recommended by the American College of Cardiology. We took a very neutral position on it, but as I reflected to you, it is a position that we think ought to change over time.

Q. What percentage of false positives, if you know, are there when people go through exercise stress testing?
A. It depends on the population, Rhett. If you go, if you take a group of patients who have disease, all positives are positives. If you take a group of patients who have no disease, all positives are false positives. So it has to be clearly defined by what the population is.
In addition, you have to define what you are trying to predict. Are you predicting coronary artery disease? Are you predicting myocardial infarctions and sudden death? Because it's different.
So it depends on your definition, it depends on the population studied, and it depends on the end point you're trying to predict, and also the criteria you use to define positive.
Q. Based on the medical monitoring class definition you have from Dr. Burns or that you have read, at least, have you made any attempt to figure out what rate of false positives would occur insofar as it relates to EKG and stress exercise testing?
MS. CROOKS: Hold on a second. I want to object to form, and I would like for you to

define the class that you want him to answer the question about.
MR. KLOK: I already explained that.
Q. You may answer the question, Dr. Thompson.
MS. CROOKS: If you don't know the class that he is talking about, don't answer the question. Unless you know exactly what the question is, don't answer it.
A. Well, I really don't know the class, but if you can direct me to it in here, I'll try.
MR. KLOK: We have to go off the record.
(Recess: 5:35 to 6:00 p.m.)
BY MR. KLOK:
Q. Dr. Thompson, do you know what resources would be available in West Virginia if the plaintiffs succeeded in this case for screening tests?
MS. CROOKS: Objection; form.
Q. Dr. Thompson, have you ever practiced medicine in the state of West Virginia?
A. I practiced pretty close, at the University of Pittsburgh, and had a fair number of patients from West Virginia; but the unequivocal answer is no.

Q. Have you ever consulted with West Virginia hospitals regarding health care in West Virginia?
A. I have lectured at the university in Charleston, and in Wheeling, and in several other hospitals in places that I can't remember; but that's the only consultation.
Q. Do you remember what the topic of your consultation was when you were at the University

hospital in Charleston?
MS. CROOKS: Object to form.
A. No.
Q. Do you remember what your consultation was when you gave a lecture at Wheeling Hospital?
MS. CROOKS: Object to form.
A. I remember one of them.
Q. What was that?
A. That was what to do when the cholesterol drugs fail.
Q. Do you remember the topic of any other lectures that you may have given in West Virginia hospitals?
A. Not specifically.
Q. Have you ever published a study regarding the health care delivery system in West Virginia?
A. No.

Q. Do you have any opinions regarding the impact of plaintiffs' medical monitoring proposals on the health care system of West Virginia?
MS. CROOKS: Object to form.
A. Not quite certain exactly what the form will take, so I cannot answer that directly.
Q. Do you have any opinions regarding the impact of plaintiffs' medical monitoring proposals on the other preventive medicine initiatives in West Virginia?
MS. CROOKS: Object to form. I'm sorry, I didn't understand your question.
MR. KLOK: I'll do it again.
Q. Do you have any opinions regarding the impact of the plaintiffs' medical monitoring proposals on other preventive medicine initiatives in West Virginia?
MS. CROOKS: Object to form.
A. I would have to be asked about the specific health initiatives in West Virginia.
Q. Dr. Thompson, have you been asked to give any comments on other experts in this case?
A. Only Dr. Burns.
Q. Do you have any other opinions that you can express in this case that you have not expressed

today at this deposition?
MS. CROOKS: Object; form.
A. Yes.
Q. What are they?
A. I mean, there are lots. What have you got for time?
Q. Well, we briefly discussed your opinions on stress exercising, correct?
A. Yes.
Q. Are there any other opinions that you haven't discussed about stress exercising that you wish to express that would have any bearing on your testimony in this case?
MS. CROOKS: I object to form, and I think if you have specific questions, you should ask them, because that would be difficult, for someone to pull any opinion he might have out of the air

without having a specific question.
A. Can we pause for a minute?
Q. Sure.
(Pause in proceedings.)
BY MR. KLOK:
Q. Dr. Thompson, if you could.
A. Well, what's the question?
Q. Do you understand the question,

Dr. Thompson?
A. Can you repeat it for me, Rhett, just so I'm certain.
Q. Yes. You've discussed numerous opinions today about EKG testing, and I'm asking you whether there are any other opinions about EKG testing that you anticipate talking about in this case.
MS. CROOKS: Object to form, and other objections as well.
A. I think we have probably hit most of them. I don't have total recollection, Rhett, of what exactly I've said.
I'm not used to doing this, so I sometimes get a little tied up in what I'm thinking about, but my overall opinion is that the class or the group that's actually going to get tested is wide, and so it's hard for me to know who is actually going to get tested.
Two, some of the things, like with respect to EKG, it is something that many physicians would do anyway, and not specific to somebody that's smoking, and that's not necessarily to detect disease, but to have a baseline.
Three, exercise stress testing is not all it's cracked up to be; and four, and I think I've

said this, I think you have a great -- in fact, I believe you have a probability of doing more harm than good.
My opinion is that people should not be smoking. I don't want to see something additional put on them that they don't necessarily need. I think it will be great for physicians.
Q. You also discussed today about exercise stress tests, and what I am asking you is whether or not there is anything that you have expressed about exercise stress tests that you anticipate to use in your testimony in this case.
MS. CROOKS: Object to form.
A. I guess it depends on what I'm asked in trial or whatever.
Q. Do you think exercise stress tests are unnecessary?
A. Depends on who they are done on. If someone comes into my office or the emergency room with symptoms with a high probability of being heart disease, then they are extremely useful. If they are done in people who are asymptomatic, and even those with considerable risk, hard to define, but they actually seem to not be useful; and actually, as I presented, have the risk of doing more harm

than good.
You recall that even the American College of Cardiology suggested that stress testing in some instances was a class 3, which means it does more harm than good.
So these aren't my opinions, but the opinions of probably the best group that sat together to put the recommendations down. I think they supersede the American College of Sports Medicine of which I've been a president, and anything before it. Very good group.
Q. Doctor, if I could, could we see that pamphlet that you have for the ACC.
A. Yes.
Q. This document is entitled, "American College of Cardiology, ACC," forward slash, "AHA Practice Guidelines: Guidelines for Exercise Testing," and underneath that it says, "Report of the American College of Cardiology and the American Heart Association Task Force on Practice Guidelines, Committee on Exercise Testing."
Dr. Thompson, what was your involvement with this pamphlet or publication?
A. I sat on the committee, reviewed data, listened to discussion, reviewed the document, and

contributed some written sections.
Q. Which written sections did you actually contribute in that --
A. I can't remember --
Q. -- publication?
A. -- exactly, but they had to do with the risks of exercise. It's been five years, so I don't actually remember.
Q. If you could, why don't you look through it quickly and just tell me, if you could, which ones you contributed, which articles you contributed.
A. Well --
MS. CROOKS: Object again.
A. In terms of articles to contribute, I think you just need to go to the references. I don't know which one it is, but one of the references I believe is to one of our articles.
Q. Were there any guidelines or recommendations made in that publication regarding smoking and health?
A. I can't recall.
MS. CROOKS: The document speaks for itself.
Q. Do you remember whether or not you had any

opinions about smoking and health when putting together that publication?
A. Yes.
Q. What were they?
A. Well, I've always had opinions about smoking and health. I don't think smoking is good for your health.
I was still working on the question three

questions good. Reference 245 is a reference to one of my studies, and so the area I contributed most likely is pretty close to where that reference appears, so I'm close here. I'll find it in a minute.

I contributed to page 293, the paragraph starting before "Fitness Program." I contributed to page 291, "Population Screening," and then just to the overall discussion. I can't find all the places that I think I had a contribution.

Q. Okay.

A. You know, one of the things that happens with a document like this is it's discussed, and we all kind of contribute to changes.

Q. If you look at your opinion at the last line of the first page, at least starting there, it says, "Dr. Thompson is also expected to testify that

the medical monitoring program advocated by plaintiffs should not be implemented and is not medically or reasonably necessary."

Do you see that?

A. Yes.

Q. When that is written there, are you anticipating to testify over and beyond the area of cardiology?

A. No.

MR. SILVESTRI: Dr. Thompson, I thank you for your time. I have no further questions for you.

MS. CROOKS: Can we take a little break?

(Recess: 6:03 to 6:10 p.m.)

MS. CROOKS: I have no further questions.

MR. KLOK: All right. Is that it for everyone?

MS. CROOKS: Does anyone there have any questions? Is there anyone there?

MR. HOLTZAPFEL: No questions.

MR. CORNFELD: No questions.

MR. PELUMBO: No questions.

MR. DASCOLI: Segal Law Firm, no

questions.

MR. KLOK: All right. Thank you gentlemen.

(Deposition concluded: 6:05 p.m.)

J U R A T

_____
Paul D. Thompson

Subscribed and sworn to before me on this _____ day of _____, 2000.

_____
Notary Public.

My Commission expires: _____

INDEX

EXHIBITS

Reporter's note: Exhibits 1 and 4 retained by counsel.

A. WILIAM ROBERTS, JR., & ASSOCIATES